Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	AL11968662	A. BUILDING: _____ B. WING _____	12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALL ALF 1 LLC	9700 SW 106TH CT MIAMI, FL 33176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments AMENDED A complaint investigation (complaint number 2019019081) was conducted at Kendall ALF 1, LLC on [redacted] and concluded on [redacted]. Deficiencies were identified at the time of the survey.	A 000		
A 025 SS=G	429.26(7) FS; 59A-36.007(1) FAC Resident Care - Supervision 429.26 (7) The facility must notify a licensed physician when a resident exhibits signs of [redacted] or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such [redacted]. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition. 59A-36.007 An assisted living facility must provide care and services appropriate to the needs of residents accepted for admission to the facility. (1) SUPERVISION. Facilities must offer personal supervision as appropriate for each resident, including the following: (a) Monitoring of the quantity and quality of resident diets in accordance with rule 59A-36.012, F.A.C. (b) Daily observation by designated staff of the activities of the resident while on the premises, and awareness of the general health, safety, and physical and emotional well-being of the resident. (c) Maintaining a general awareness of the	A 025		

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A 025	Continued From page 1 resident's whereabouts. The resident may travel independently in the community. (d) Contacting the resident's health care provider and other appropriate party such as the resident's family, guardian, health care surrogate, or case manager if the resident exhibits a significant change. (e) Contacting the resident's family, guardian, health care surrogate, or case manager if the resident is discharged or moves out. (f) Maintaining a written record, updated as needed, of any significant changes, any illnesses that resulted in medical attention, changes in the method of medication administration, or other changes that resulted in the provision of additional services. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision as appropriate and failed to contact the resident's healthcare provider and family in a timely manner after a significant change for one out of six sampled residents (Resident # 1). Resident # 1 was hospitalized due to a after falling in the facility. The facility also failed to maintain an updated written record which reflected Resident # 2's significant changes. Resident # 2 developed three , under hospice care and there was no documentation of any care being provided to the resident. Findings Included: 1) A review of Resident # 1's admission and discharge log showed Resident # 1 was admitted to the facility on and discharged on . The log stated that the reason for	A 025		

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A 025	Continued From page 2 discharge was because of "family decision". A review of Resident # 1's progress notes showed a progress note dated that stated 'While having Easter dinner with the family at son's house, [Resident # 1] and hurt herself in the , impacting her right , . Her granddaughter who is a PA (physician assistant) checked her out and she was returned to the ALF (Assisted Living Facility). Upon calling doctor the next day, doctor wished for resident to go to the hospital. Family refused and are deciding to send her here. Family is concerned that a stay in the hospital would be worse and bring other problems. Administrator had lengthy conversation with daughter and granddaughter and both were very determined for her not to go to the hospital' On at 1:42 pm, Staff B stated regarding the resident's right , injury " in , , I ran it by a healthcare professional which was her granddaughter". A review of Staff B's text messages between her and Resident # 1's granddaughter revealed that the granddaughter was giving medical advice to Staff B and Staff B asked for medical advice to the granddaughter. A review of Resident # 1's records showed no documentation that stated Resident # 1's granddaughter was Resident # 1's healthcare provider. There was no documentation that Resident # 1's granddaughter was licensed as a Physician's Assistant. There was also no documentation of actions the facility took to prevent Resident # 1 from falling again. On at 1:42 pm, Staff B stated "On Easter day, she at her son's house. She came like at 9 o' clock. I called the next Monday, the daughter	A 025		

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A 025	Continued From page 3 and doctor. The doctor in the very beginning said that she didn't want to treat her until she was seen at the hospital. I had told her [Resident # 1] had something in her . The family told me that they just cleaned her up. The doctor told me that she at least needed an [ ] scan. The son then came after and applied a butterfly bandage to have the closed". On at 4:56 pm, an interview with Resident # 1's Primary Care Physician (PCP) revealed that the last time Resident # 1 was seen by her was on due to an annual physical. The PCP stated that she did not know of the until the physical, where she had noticed Resident # 1 had to the right and a bump on her . The PCP also stated that she did not have any notes of the administrator contacting her to consult when Resident # 1 had . Further review of Resident # 1's progress notes showed a second note dated stating "[Resident # 1] while going to restroom at 2:26 am (approx.). She hit left side of and . Rescue was called at 2:52 am and she was taken to nearby [local hospital] where she is admitted under observation. Again family upset she was sent to hospital calling it was not my job to do so. Contacted daughter who was very upset". On at 12:43 pm, Staff C stated "I worked 7 PM - 7 AM. I was working alone. It was at night time she . I don't know exactly what happened. I heard a noise that someone was calling me. I found her sitting closed in her room on the floor. [Resident # 1] said she from the bed. I told her she didn't because she was far from the bed. She had a small cut on her left .	A 025		

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A 025	Continued From page 4	A 025		

I called [Staff B] and she said to call 911. 911 came really quick. [Resident # 1]wanted to talk to her daughter or her niece. She didn't have a bed rail. She never used one. It was her first time falling in the facility. It was around 2:10 am and 2:15 am the police came.

On at 1:02 pm, Staff C stated "I check on the resident 3 to 4 times throughout the night. I check whenever I want. We don't do hourly rounds". At 1:21 pm, Staff C stated, "She used adult diapers. I saw her at 6 pm during dinner, 7 pm was medication. I would take her medication and a bottle of water to her room. She would use the bathroom at night multiple time because she told me she didn't like to urinate in the diaper. Various times she would use the bathroom. I would go with her to the bathroom. That day we don't know if she went to the bathroom. That day I heard her call my name and the door was open. I would know when someone has to use the bathroom by hearing them call me. Between 7 and 730 pm was the last time I saw her because of her medication. She was in the bathroom alone".

Further review of Resident # 1's records showed a completed health assessment dated and revealed she was diagnosed with , , , , , , ( ), and , . The health assessment also showed Resident # 1 had "poor balance, forgetful" and had precautions. Resident # 1 required assistance in Ambulation, Eating, and Transferring along with Supervision with Bathing, , Self-Care (grooming), and Toileting.

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A 025	Continued From page 5 A review of Resident # 1's hospital records showed she was admitted to the hospital on and was discharged on . Resident # 1 was diagnosed with Hematoma, Periorbital Hematoma, Accidental from bed, , Frequent , and Dental . Documentation showed the resident informed the hospital that she got up from bed and ambulated to the bathroom when she facing forward and hit the left side of her against a chair. Further documentation showed Resident # 1 had (discoloration of the skin) to the left (upper jaw), and significant ( ) to the left side of the . Resident # 1 also had a (deep cut) to the left measuring 1 cm and moderate chemosis ( ) to the left conjunctiva (tissue that lines the inside of the). A second evaluation conducted at 4:45 am showed she had a developing large left hematoma (localized outside of). Further review of Resident # 1's hospital records showed a Computed (CT) Scan (described by the Mayo Clinic as a combination of images taken from different angles around the body which uses computer processing to create cross sectional images of tissues or bones) revealed Resident # 1 had a hematoma (type of in which a collection of between the and its tough outer covering - usually associated with a). A second re-evaluation showed the resident's large hematoma was mildly expanding. Documentation stated that the hematoma and made it difficult to inspect Resident # 1's and required force pulling of the for assessment. Further documentation	A 025		

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A 025	Continued From page 6 also showed that the resident was very . . . . screaming in , because of her . Documentation also stated that the doctor was not able to re-evaluate the , because the hematoma was ". . . . shut". On . . . . at 5 pm, Resident # 1's daughter stated "She stated that she didn't get a call until 9 o clock in the morning the next day after her mother had . She was very upset she wasn't called right away. She stated: What if my mother had . at the hospital and I wouldn't have known because the administrator never called me right away to tell me my mother had gone to the hospital, much less had at the house. She could've called me right when she had called 911. If I wouldn't have picked up, at least I would've known she tried to call me, but she didn't". On at 3:16 pm, Staff B stated, "We did everything that we could for [Resident # 1] to get the best care that she needed". 2) On at 12:49 PM, Staff C stated that Resident #2 . . . under hospice continuous care. On . . . . at 12:55 PM, Staff A stated that the hospice record for Resident #2 was not at the facility. Staff C had Resident #2's hospice record in her car. On at 1:01 PM, Staff C arrived with Resident # 2's hospice record. A review of Resident # 2's hospice records showed that the resident started receiving hospice services on . . . . . due to being diagnosed with . Hospice	A 025		

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A 025	Continued From page 7 records revealed Resident # 1 had three , on and was receiving care. She had a in the lower , a on the left , and a on the right , . There was no documentation stating the resident was under continuous care or that Resident # 2 had . On at 1:48 PM, Staff C stated that Resident # 2 was on continuous care the last day before she had . She documented in the resident's record. At 1:58 PM, Staff C added that Resident # 2 had problems eating and breathing. The resident had one or two , when she . The facility provided reposition to the resident all the time as recommended by the hospice nurse. A review of Resident # 2's records showed no documentation that Resident # 2 was being repositioned to prevent , . Further review of Resident #2's record showed no documentation of her PCP's information and her health assessment dated showed no information on the or . Furthermore, the health assessment did not indicate that the resident had any , 3, or 4 , or that she was bed bound. A review of the facility's progress notes for Resident # 2 completed on showed that she started receiving continuous care services from hospice on . The note completed on showed that the resident at 6:30 AM. There was no documentation showing that the resident had , or if the , were being treated by a healthcare professional.	A 025		

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A 025	Continued From page 8 A review of Resident # 2's hospice records indicated that she received continuous care from to . Documentation showed Resident # 2 had received continuous care was due to , distress and had on at approximately 5 am. A review of Resident # 2's certificated showed the cause of was due to Acute Hypoxic , Failure. Class II	A 025		
A 027 SS=D	59A-36.007(3) FAC Resident Care - Arrangement for Health Care (3) ARRANGEMENT FOR HEALTH CARE. In order to facilitate resident access to health care as needed, the facility must: (a) Assist residents in making , and remind residents about scheduled , for medical, dental, nursing, or mental health services. (b) Provide transportation to needed medical, dental, nursing or mental health services, or arrange for transportation through family and friends, volunteers, taxi cabs, public buses, and agencies providing transportation. (c) The facility may not require residents to receive services from a , health care provider. This Statute or Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that one out of six sampled residents (Resident # 1) received dental services.	A 027		

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A 027	Continued From page 9 Findings included: A review of the hospital records showed Resident # 1 went to the hospital on due to falling at the facility and was discharged from the hospital on . A CT (Computed) Scan (described by the Mayo Clinic as a combination of images taken from different angles around the body which uses computer processing to create cross sectional images of tissues or bones) revealed the resident had a large left periorbital soft tissue hematoma (around the) and multiple dental . Further review of hospital records showed that Resident # 1 received medication four times a day every 6 hours from to to treat the . According to the hospital's discharge summary, a dental is a collection of pus in or around a that results from an . The can cause severe , redness and drainage of pus in and around the . The dental access may result from severe decay, to the , or severe around a . A review of Resident # 1's records showed a completed health assessment dated and showed she was diagnosed with , , , , , , and . There was no documentation stating Resident # 1's health conditions were like to have a buildup of pus occur or any documentation Resident # 1 required dental services.	A 027		

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A 027	Continued From page 10 On at 3:16pm, Staff B stated "We did everything that we could for [Resident # 1] to get the best care that she needed". Class II	A 027		
A 079 SS=D	59A-36.010(3) FAC Staffing Standards - Levels (3) STAFFING STANDARDS. (a) Minimum staffing: 1. Facilities must maintain the following minimum staff hours per week: Number of Residents, Day Care Participants, and Respite Care Residents Staff Hours/Week 0-5 168 212 16-25 253 26-35 294 36-45 335 46-55 375 56-65 416 66-75 457 76-85 498 86-95 539 For every 20 total combined residents, day care participants, and respite care residents over 95 add 42 staff hours per week. 2. Independent living residents, as referenced in subsection 59A-36.015(3), F.A.C., who occupy beds included within the licensed capacity of an assisted living facility but do not receive personal, limited nursing, or extended congregate care services, are not counted as residents for purposes of computing minimum staff hours. 3. At least one staff member who has access to facility and resident records in case of an	A 079		

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A 079	Continued From page 11 emergency must be in the facility at all times when residents are in the facility. Residents serving as paid or volunteer staff may not be left solely in charge of other residents while the facility administrator, manager or other staff are absent from the facility. 4. In facilities with 17 or more residents, there must be at least one staff member awake at all hours of the day and night. 5. A staff member who has completed courses in First Aid and [illegible] ( ) and holds a currently valid card documenting completion of such courses must be in the facility at all times. a. Documentation of attendance at First Aid or courses pursuant to subsection 59A-36.011(5), F.A.C., satisfies this requirement. b. A nurse is considered as having met the course requirements for First Aid. An emergency medical technician or paramedic currently certified under chapter 401, part III, F.S., is considered as having met the course requirements for both First Aid and [illegible]. 6. During periods of temporary absence of the administrator or manager of more than 48 hours when residents are on the premises, a staff member who is at least [illegible] must be physically present and designated in writing to be in charge of the facility. No staff member shall be in charge of a facility for a consecutive period of 21 days or more, or for a total of 60 days within a calendar year, without being an administrator or manager. 7. Staff whose duties are exclusively building or grounds maintenance, clerical, or food preparation do not count towards meeting the minimum staffing hours requirement. 8. The administrator or manager's time may be counted for the purpose of meeting the required	A 079		

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A 079	Continued From page 12 staffing hours, provided the administrator or manager is actively involved in the day-to-day operation of the facility, including making decisions and providing supervision for all aspects of resident care, and is listed on the facility's staffing schedule. 9. Only on-the-job staff may be counted in meeting the minimum staffing hours. Vacant positions or absent staff may not be counted. (b) Notwithstanding the minimum staffing requirements specified in paragraph (a), all facilities, including those composed of apartments, must have enough qualified staff to provide resident supervision, and to provide or arrange for resident services in accordance with the residents' scheduled and unscheduled service needs, resident contracts, and resident care standards as described in rule 59A-36.007, F.A.C. (c) The facility must maintain a written work schedule that reflects its 24-hour staffing pattern for a given time period. Upon request, the facility must make the daily work schedules of direct care staff available to residents or their representatives. (d) The facility must provide staff immediately when the agency determines that the requirements of paragraph (a) are not met. The facility must immediately increase staff above the minimum levels established in paragraph (a), if the agency determines that adequate supervision and care are not being provided to residents, resident care standards described in rule 59A-36.007, F.A.C., are not being met, or that the facility is failing to meet the terms of residents' contracts. The agency will consult with the facility administrator and residents regarding any determination that additional staff is required. Based on the recommendations of the local fire	A 079		

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A 079	Continued From page 13 safety authority, the agency may require additional staff when the facility fails to meet the fire safety standards described in rule chapter 69A-40, F.A.C., until such time as the local fire safety authority informs the agency that fire safety requirements are being met. 1. When additional staff is required above the minimum, the agency will require the submission of a corrective action plan within the time specified in the notification indicating how the increased staffing is to be achieved to meet resident service needs. The plan will be reviewed by the agency to determine if it sufficiently increases the staffing levels to meet resident needs. 2. When the facility can demonstrate to the agency that resident needs are being met, or that resident needs can be met without increased staffing, the agency may modify staffing requirements for the facility and the facility will no longer be required to maintain a plan with the agency. (e) Facilities that are co-located with a nursing home may use shared staffing provided that staff hours are only counted once for the purpose of meeting either assisted living facility or nursing home minimum staffing ratios. (f) Facilities holding a limited mental health, extended congregate care, or limited nursing services license must also comply with the staffing requirements of rules 59A-36.020, 59A-36.021 or 59A-36.022, F.A.C., respectively. This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a written work schedule that reflected its 24-hour staffing pattern.	A 079		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENDALL ALF 1 LLC	9700 SW 106TH CT MIAMI, FL 33176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 079	Continued From page 14 Findings Included: On during the tour of the facility, observed a work schedule posted on the facility's bulletin board. A review of the facility's staffing calendar revealed that it was for the month of . The staffing pattern revealed the following shifts every day: A) 7AM - 7PM B) 7PM - 7AM and C) 7AM - 7PM. The schedule also showed Shift A could be either "[Staff A] or [Staff B] or [Staff D]; Shift B could be either [Staff A] or [Staff B]; and Shift C could be either "[Staff A] or [Staff B] or [Staff C]. There was no evidence of a written work schedule for the month of . On at 12:43pm, Staff C stated "I work from 7PM - 7AM. I was working alone". On at approximately 12:35pm, Staff B stated that the schedules do not change and it's the same schedule for the month of . "I don't know what happened to the schedule for ". Class III	A 079		

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CZ824 SS=C	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by authorizing statutes or applicable rules. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an	CZ824		

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Agency for Health Care Administration

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CZ824	Continued From page 1	CZ824		

offsite review.
(4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency.
(5) The agency may require an applicant or licensee to submit a plan of correction for deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required.
(6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership.
(b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection.

59A-35.120 Inspections.
(1) When regulatory violations are identified by the Agency:
(a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency

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CZ824	Continued From page 2 notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time. (2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency. (3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide: (a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation. (b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection. This Statute or Rule is not met as evidenced by: Based on observation and interview, the facility failed to maintain resident records including medical and treatment documentation for one out of six sampled residents (Resident #2). Findings included: On at 12:49 PM, Staff C stated that Resident #2 under hospice continuous care.	CZ824		

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CZ824	Continued From page 3 On at 12:55 PM, Staff A stated that Resident # 2's hospice record was not at the facility and is in Staff B's car. On at 1:01 PM, Staff C arrived with the hospice record. Unclassified	CZ824		